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Muscle Memory: Exploring the Sociocultural Factors of Sexual Pain in People Assigned Female at Birth

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ABSTRACT

According to the American Congress of Obstetrics and Gynecology, "nearly 3 out of 4 women have pain during intercourse at some time during their lives," which is an under-researched issue, especially when it comes to factors outside of biology (2017). This research paper focuses on examining the most common sociocultural aspects that affect sexual pain in people assigned female at birth (AFAB) between the ages of 18 and 30. A survey was completed by 144 participants, 6 of whom participated in structured interviews. My analysis shows a strong impact of sociocultural factors on experiences of pain during sex in participants. 90.28% of participants had experienced pain during sex at least once in their lives. Seven themes were identified from the data: (1) situations that cause pain, (2) pain during first intercourse, (3) normalization of pain, (4) pain is not "a big deal," (5) shame, (6) pressure, and (7) expectation of pain during sex.

1. Introduction

"There's something wrong there, and I want a complete [autopsy] because I know there's something else that he has not found, or he's done, and he knows he's done wrong. I would like that that be done" (Public Broadcasting Service, 1991). These are the words of Marjorie Wantz, a woman who ultimately chose to end her own life due to her "untreatable" chronic vaginal pain which her doctor could never find a cause or a treatment for. Her hopelessness and her story, although one of the most devastating, mirrors the hopelessness that the normalization of painful reproductive disorders can foster for many women. According to the American Congress of Obstetrics and Gynecology, "nearly 3 out of 4 women have pain during intercourse at some time during their lives," (2017) with some only lasting temporarily, and some lasting lifespans, like Marjorie's story. Heather Davidson, author of Effective treatment of women's pelvic and sexual pain disorders: healing the body and mind during the #MeToo era, draws many parallels between the trauma of experiencing sexual violence and the repetitive invalidation of women's concerns about sexual pain. She suggests that chronic pelvic/sexual pain is a trauma in itself, even after it is cured.

I experienced this pain myself. As I grew into my own sexuality, and was later diagnosed formally with vaginismus, I experienced the weight that sexual pain can hold. Although we might push it off as normal and something to be overcome with age and experience, I have

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lived with the anxiety caused by my disorder throughout my entire life. Sex was not easily separated from life, and the frequent experiences of pain left me feeling broken, inadequate, and full of self-hatred in all aspects of my life outside of the bedroom. It was important to me to research this topic, as I have explored a small community of women online who have opened up about their experiences with vaginismus diagnoses and shared their stories of overcoming painful sex. But unfortunately, this experience of opening up about pain seems to be the minority. I have spent many hours in the pelvic floor physical therapy office and online, desperately trying to fix myself, where I learned about women who felt more hopeless, scared, and stuck than I did. In fact, I made it further than a majority of women, who often leave their pain in the bedroom where they believe it is supposed to belong.

Pelvic and sexual pain can have a lasting impact on not only bodies, but also quality of life, including relationships, finances, and one's ability to go about daily life amidst pain and turmoil (Davidson, 2023, p. 40). This research paper seeks to decipher some of the sociocultural factors that contribute to painful sex for people who are assigned female at birth (AFAB). There is a broad lack of research about genito-pelvic pain/penetration (GPP/PD) disorders, especially when it comes to how they are affected by factors outside of biology.

The purpose of this study is to determine if there is an association between specific sociocultural factors (such as religion, media consumption, and access to sexual health education) and experiences of painful penetrative sexual intercourse amongst AFAB people between the ages of 18 and 30. The goal was to analyze how U.S. culture may affect AFAB people's experiences of painful penetrative sexual intercourse, and if the pain AFAB people experience during penetrative sexual intercourse is normalized. The central research question of the study is "Is there an association between sociocultural factors and experiences of painful sex in people assigned female at birth between the ages of 18 and 30?" I hypothesize that sociocultural factors have a significant effect on whether or not AFAB people experience pain during penetrative sexual intercourse and normalization of that pain.

2. Literature Review

2.1. Types of Sexual Pain Disorders

For the sake of this study, experiences of sexual pain for which there is a medical diagnosis are referred to as sexual pain disorders. Although some contest the word disorder due to the slightly negative connotation and the categorization of sexual pain in the DSM as a psychological issue rather than a physical one, it is the most easily identifiable term to describe these experiences of sexual pain. There are many different reasons that an AFAB person could experience sexual pain, some situational and some medical, "including interstitial cystitis, urinary tract infection, atrophic vaginitis, pelvic inflammatory disease, endometriosis, candida, childbirth and vulvodynia" (Campbell, 2020, p. 106). Situational reasons for pain include lack of arousal and lubrication, size of the partner's penis, and positioning during sex (Mitchell et al., 2017; Prause et al., 2015; Sörensdotter, 2017). Some of the most common conditions outside of infections and conditions related to menstruation are chronic pelvic pain, vulvodynia, dyspareunia, and GPP/PD. Chronic pelvic pain is defined as "pain in the lower abdomen and pelvis, lasting for more than six months with no apparent organic cause" and can later cause sexual pain when associated with arousal (Campbell, 2020, p. 106). Vulvodynia refers to "chronic pain of the vulva when no cause is found" that feels like "itching, burning, stabbing, stinging, aching, or irritation" ("Vulvodynia," 2023). Dyspareunia is "persistent or recurrent pain with attempted or complete vaginal entry or penile-vaginal intercourse" (Lee, et al., 2018, p. 1). Many of the listed disorders have overlap and have been defined differently over time (Goldstein, 2018, p.

267). Because there is no one clear cause for any of the disorders, there is no clear way to define them without overlap or debate, and the language surrounding them is constantly changing.

The focus of this study, GPP/PD, is defined in the DSM-5 as "[encompassing] both vaginismus (difficulty with penetration) and dyspareunia (painful intercourse)" (American Psychiatric Association, 2013). GPP/PD includes the aforementioned symptoms as well as "fear of pain as a result of penetration," "tensing or tightening of the pelvic floor muscles," and sometimes "the development of vulvodynia" (Campbell, 2020, p. 107). A common result of GPP/PD is "anxiety, inability to relax and muscle tension" along with pain avoidance, hypervigilance, self-confidence issues related to lack of desire from sexual partners, and depression (Campbell, 2020, p. 106). Many more people experience GPP/PD than those who report it due to fear, shame, or lack of resources and knowledge that their condition exists.

2.2. Treatments for GPP/PD

One method of treatment for sexual pain disorders is pelvic floor physical therapy. This often consists of both regular visits to a physical therapist who can assist with stretching the pelvic floor muscles to gradually release tension and pain and home exercises to maintain continuity in treatment, such as the use of vaginal dilators, genital exploration, and gradually practicing sex with a partner (Campbell, 2020, p. 10).

Another common form of treatment that gets prescribed to people who complain of sexual penetration pain are methods of invasive desensitization. These methods range from "intravaginal injection of Botox" to topical medications like lidocaine cream to numb the area (Farrell & Cacchioni, 2012, p. 331). This is not typically supported by "many sexual pain experts [who] advocate for the least invasive approaches with fewer side effects" (Farrell & Cacchioni, 2012, p. 332).

Although psychosocial therapy is helpful and sometimes necessary to break down the sociocultural factors that can affect the disorder, it is often the only referral a person receives when they report feelings of sexual pain, if they receive one at all. It is a common experience to see multiple doctors looking for an answer. Many doctors give no solution or sometimes even deny the person's pain (Campbell, 2020, p. 108-109). It is important that doctors refer patients to additional medical practitioners (such as pelvic floor physical therapists) outside of mental health therapy to avoid teaching "clients to tolerate unnecessary pain" through sole psychological treatment (Campbell, 2020, p. 106).

2.3. Causes and Sociocultural Factors

Modern biological and medical understandings of GPP/PD "typically reduce broader social and structural forces that directly influence women's experiences of sexual pain to individual, psychological, or interpersonal 'abnormalities,' rather than framing them as influenced by social determinants" (Farrell & Cacchioni, 2012, p. 330). GPP/PD disorders are unusual because they often have no clear cause and are "usually seen in young and seemingly healthy females" (Ait Souabni et al., 2023, p. 328). There is also a deep-rooted "normalization of painful sex in Western culture, which may thereby lead to under-reporting or minimizing of pain that does not seem intense or frequent enough" by the women who experience it (Azim et al., 2021, p. 778). GPP/PD disorders are hypothesized to be somewhat psychological and affected by the sociocultural factors surrounding the person, but research on what these sociocultural factors are and how much of an effect they have on the person experiencing the pain is limited. This idea of sociocultural impacts on sexual pain is further exemplified by

Heather L. Davidson, who, in her novel about pelvic pain, asks the question "What is your pelvis holding?" (Davidson, 2023, p. 12).

In an analysis of the 2018 National Survey of Sexual Health and Behavior, roughly 30% of the participants reported that their pain was normal, typical, or expected (Carter, 2019, p. 1959). This normalization goes as far as to be reinforced by health care practitioners, who often respond to patients' acknowledgement of their pain by "[reinforcing] the idea that pain was a normal part of having sex," leaving people with this experience feeling hopeless (Carter, 2019, p. 1960). People often seek out online communities for support because of invalidating healthcare experiences and taboos in their communities that prevent them from finding treatment and support (Piszczek et al., 2021, p. 547.e1).

2.4. Religion and Sex Guilt

One potential sociocultural factor is religion and the beliefs surrounding female sexuality. Religious cultures can create "a breeding ground for the creation of a negative genital self-image" due to repeated negative talk about the loss of virginity and expressions of female sexuality (Ait Souabni et al., 2023, p. 328). Many religions, such as Christianity, Islam, and Judaism, place a lot of focus on the sanctity of marriage and virginity for women. Although virginity is not discussed with frequency in the Bible, "Deuteronomy's violent vision of virginity has held sway in Jewish and Christian circles" (Rosenberg, 2018). However, "it is not religiosity per se that increases painful sex but religiosity that causes sex guilt" (Azim et al., 2021, p. 779).

Sex guilt is defined as "a generalized expectancy for self-mediated punishment for violating or anticipating violating internalized standards of proper sexual conduct" (Divasto, 1981, p. 119). Sex guilt as referred to in this study is any guilt felt surrounding sexual acts as a result of sociocultural factors or one's understanding of their sexual condition. Sex guilt can "act as a barrier for women to communicate their pain to partners, healthcare providers, and ultimately seek and receive treatment, which then reinforces their suffering physically, emotionally, and relationally" (Azim et al., 2021, p. 779).

2.5. Lack of Comprehensive Sex Education

Another sociocultural factor is lack of access to comprehensive, medically accurate, evidence-based sex education. For example, "GPP/PD rates are high in Muslim countries compared with the Western world," countries in which sex is too taboo of a topic to provide education, leaving women and girls to look towards the internet and stories of painful virginity loss from close family members and friends (Ait Souabni et al., 2023, p. 332). In a review of the sociocultural factors affecting GPP/PD in Muslim societies, Ait Souabni et al. find "a lot of patients express irrational fears like bleeding to death or having disproportionate or incompatible genitalia," which could be corrected in the intervention of comprehensive sex education (2023, p. 328). In some cultures, there is "the assumption that the presence or absence of the hymen is an accurate indicator of a woman's prior sexual experience," which although disproved, has continually been held over women's and girls' heads as the symbol and proof of sexual purity (Abboud et al., 2015, p. 11). This assumption is rife not just in outside religious cultures, but in the United States as well, with popular figures such as T.I. admitting to checking their children for virginity through regular examinations of the hymen (Beaumont-Thomas, 2019).

2.6. Virginity

Virginity is a complex issue that varies in definition based on factors such as culture and sexual orientation. In her novel, "Virginity Lost: An Intimate Portrait of First Sexual Experiences," Laura Carpenter spends chapters debating how to define virginity through the perspectives of many different people, but no one can come up with a clear answer (2005). Like many others, she agrees that virginity is socially constructed and is entirely reliant on sociocultural understandings and teachings of virginity (Carpenter, 2005). There seems to be "two different virginities: the first was the participant's, a lived being, and the second was a separate entity for the world to evaluate" (Abboud et al., 2015, p. 8). This objectification of virginity by society often comes at the pressures and teachings of others rather than the woman herself. In some cultures, virginity is framed as a "loss," whereas in others it can be perceived as a "debut" or "coming of age." In the case of a Muslim woman who was interviewed about her virginity she said that, "she was not ashamed of losing her virginity until her boyfriend made her feel ashamed and consequently, she considered undergoing virginity restoration but never did" (Abboud et al., 2015, p. 8). In contrast, "men have expectations and experiences of first coitus that are generally more positive than those of women," possibly due to the negativity surrounding the loss of virginity for women (Barnett et al., 2016, p. 27).

The concept of virginity has a strong hold on women around the world who wait until their wedding night to have sex. In the examples of Muslim societies, it is often a customary practice "to prepare a piece of white cloth destined to get stained with drops of blood from the defloration of the young spouse" (Ait Souabni et al., 2023, p. 331). In a Dutch study focused on medical approaches to virginity-related issues, 154 women sought out help before their wedding night in hopes of restoring their virginity, either by hymen reconstructive surgery or other methods (Loeber, 2015, p. 131). Many of these women just want to be able to bleed and stain the sheets as proof of their virginity and fear repercussions from their husbands or families if they do not (Loeber, 2o15, p. 132). They go to great lengths to ensure bleeding, such as inserting food coloring capsules or sponges soaked in anti-coagulated blood into their vaginas before intercourse, pricking a finger, ordering an "artificial hymen kit" on the internet, having a temporary suture placed in their hymen to be broken on their wedding night, and even reconstructive surgery of the hymen (Loeber, 2015, p. 130).

2.7. Sexual Traumas

There are also many physical traumas that can affect GPP/PD such as sexual assault/rape, abuse, or even religious rituals/rites designed to impact a woman's virginity or sexuality. In Muslim societies there is a ritual called Tasfih that is meant to protect a girl's virginity until the spell is removed on her wedding night. Tasfih is a ritual performed by a woman in the family that is "'performed by making seven cuts on a girl's left knee or left thigh before she is 13 years old" and dipping "seven grains of raisins or wheat in the girl's blood" for her to eat (Trabelsi, 2021). There is also female genital cutting, "a traditional harmful practice that involves the partial or total removal of external female genitalia or other injury to female genital organs for non-medical reasons," that is estimated to have occurred to 200 million women and girls alive today (World Health Organization, 2019). These traumas are not to be left without consideration of culture, tradition, and the way in which they are perceived differently in Western culture than they may be in the culture of origin. Additionally, these sexual traumas that relate to the genitalia itself due to the appearance and restriction of pleasure still present in Western culture, although in a way that seems more acceptable in Western society, such as the increasing use of female genital cosmetic surgeries such as labiaplasty in the United States (Oeming, 2018, p. 1).

In terms of sexual traumas, their links to pelvic/sexual pain disorders have been increasingly noted in research around the effects of sexual trauma. Women who have experienced some sort of sexual trauma are more likely to report GPP/PD than women without a history of sexual trauma (Davidson, 2023, p. 11). This experience of sexual trauma can further complicate the ability to treat GPP/PD and related disorders due to complex psychological factors, such as PTSD. Sexual trauma can also have a physical effect on the body, causing "increased pelvic muscle tension and contractions" as a "protective mechanism in response to a threat" (Davidson, 2023, p. 38). This can turn into a resting or chronic state for women who are still living with the effects of their trauma or who are under continuous danger and instability. This can make returning to a sexual state difficult for traumatized individuals, as the body's automatic response has now changed to perceive sex as a danger or a threat which it must protect itself from.

2.8. Relationships and Gender Roles

Relationships also have some effect on sexual pain and its ability to be treated. "Partners [who] are understanding and caring, stopping intercourse/touch as soon as there is any pain," supportive of their partner, and willing to attend therapy as part of the healing process are often a vital piece of recovery from sexual pain (Campbell, 2020, p. 107). On the other end of the spectrum, in an analysis of a national survey, roughly 14% of women stated that their partner's enjoyment was prioritized, either by themselves or their partner (Carter, 2019, p. 1960). This situation often leads to women pushing through their pain in order to satisfy their partner's needs or to make them finish quicker so that it can be over. Other women from the same survey noted that another reason why they might push through their sexual pain is fear of "[ruining] the mood", making it "awkward", or fearing they will be considered "difficult" by making their partner feel insecure about their sexuality or masculinity (Carter, 2019, p. 1960).

This experience can be similar and different for non-heterosexual/queer couples. Little research has been done on painful sex within specifically queer relationships, but one Swedish study done with 5 queer women highlighted some of these similarities and differences. Some struggles that were unique to the experiences of queer women were feelings of imbalance in pleasure during sex and threats to queer feminist identities due to the inability to participate in sexual activities typically deemed "feminist" or "sexually liberating," such as casual sex (Ekholm et al., 2021, p. 1243). However, queer women have unique advantages when it comes to communication and understanding due to similar anatomy between partners and experiences of norm breaking due to being queer that aids in the acceptance of their disorder (Ekholm et al., 2021, p. 1248). Queer women with painful sexual experiences also report less avoidance of sex and less distress than heterosexual women, due to their ability to participate in sex in other ways outside of penetration (Ekholm et al., 2021, p. 1249).

This need to prioritize a partner's enjoyment, particularly in heterosexual relationships, ties deeply into gender scripts around sex and femininity. This includes ideas of "men controlling sex, penetration being normal and necessary, women being expected to assume a docile or submissive sexual persona, and women not wanting to be rude or demanding" (Carter, 2019, p. 1961).

2.9. Race and Ethnic Identity

Race and ethnic identity also plays a role. Many Muslim women associate the loss of virginity and other sexual behaviors outside of the confines of marriage as "American" behaviors and are scolded by their mothers to not be an "American" girl (Abboud et al., 2015, p. 12). In terms of race, Black and Latino women have similar rates of sexual pain to white women, but are

diagnosed and treated significantly less (Labuski, 2017, p. 160). Black women and other women of colors' pain is very often cast aside or not believed by healthcare practitioners, which may lead to the under-diagnosis and barriers to reporting GPP/PD for Black women and other women of color (Labuski, 2017, p. 160). This also aligns with sociomedical researcher Ilhan H. Meyer's theory of minority stress, or "excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position," which can be applied to quality of care and lack of inclusive support (2003, p. 3).

3. Methods

3.1. Theoretical Frameworks

Although the literature included some research focused on the normalization of sexual pain, there was still a large gap in research on the lived experiences of people who have experienced pain during sex. Even more so, research is lacking on those experiences of people who have been diagnosed with sexual pain disorders, such as GPP/PD. While there are medical journals that discuss the diagnoses and treatments of these disorders (that often come to differing conclusions), it is important to look at the experiences of the people who seek out care for sexual pain and the emotional and societal complications that come with and may complicate diagnosis and treatment. Lived experiences and engrained societal ideals cannot easily be separated from discussions about sex, and conversely should not be left out of the discussion surrounding sexual pain and sexual disorders. Due to the complicated nature of sexual pain, I use theories in analysis that pay special attention to the experiences of AFAB people who were at one time in their life socialized as women. These theories include intersectionality, Feminist Theory, and grounded theory.

Intersectionality "has two meanings: one, the social phenomenon of overlapping discrimination due to multiple social categories and power systems; and two, the way of thinking about discrimination and inequality by paying serious attention to the intersection of multiple social categories and systems" (Yang, 2024, p. 10). This theory was used to allow for the analysis of the complex interaction of sociocultural factors as it relates to one's experience of sexual pain. Sexual pain is an intersectional issue at its root, as it cannot be separated from the lived experiences and identities of the individual.

Secondly, Feminist theory was used to deconstruct ideas of androcentric bias and the female as deficit model in looking at the experiences of AFAB people as it relates to the medical issue of sexual pain. There are "sex-biased assumptions embedded within reproductive medical texts that serve to disempower women…" that is necessary to break down in order to fully capture and analyze the lived experiences of the participants in this study (Hesse-Biber, 2012, p. 10). The goal in using this theory was to provide an accurate representation and advocacy for the stories shared by the participants of this study and to further deconstruct the harmful notions of the female-as-deficit model of research on AFAB people (Pillow & Mayo, 2014, p.8).

Lastly, grounded theory is "...a way of thinking about data–processes of conceptualization–of theorizing from data, so that the end result is a theory that the scientist produces from data collected by interviewing and observing everyday life" (Morse et al., 2009, p. 18). Grounded theory was used in the analysis of the data and the development of codes. Responses to the survey and interviews were coded through a grounded theory method in which codes emerged throughout reading and were not pre-defined. This approach was taken in order to limit preconceived notions of sociocultural factors and their effects, but to instead let the experiences of the participants guide the analysis.

3.2. Participants

The target population for the survey was AFAB people between the ages of 18 and 30 who are or have been sexually active. This age demographic was chosen to collect the greatest amount of data from the available channels at the university level and to capture the experiences of those who were single, partnered, and married. There were a total of 163 participants in the initial survey. Ultimately, 19 of the 163 participants were eliminated from the survey data because they did not qualify for the study due to either a.) sex assigned at birth (either male or intersex), b.) they were not sexually active, c.) they were above the age of 30 years old, or d.) they submitted incomplete data. Incomplete data was determined by whether or not the participant completed the questions related to pain during sex and/or some of the fill-in-the-blank responses. Therefore, this analysis includes analysis of 144 participant responses. Ethics approval was gained from the Institutional Review Board before any recruitment took place.

My goal was to reach as diverse a group as possible to represent the many different identities encompassed with AFAB people between 18 and 30. This was important to the nature of the study due to the way that intersectional identities contribute to the sociocultural factors someone might experience, especially as it relates to painful sex. Many participants were recruited through university channels such as Instagram and direct outreach to professors who shared the survey with their students. To compensate for the lack of participants above the age of 22 and for the lack of non-white participants identified during data collection, I additionally recruited using ResearchMatch to reach a more diverse group.

3.3. Data Collection Methods

A survey and an optional interview were the data collection methods for this study. Participants first completed a 15-20 minute survey with a mixture of closed and open-ended questions. The survey included a brief content warning for participants that explained to them the nature of the study and that it contained content that could be triggering for individuals who have experienced sexual traumas such as sexual assault. At the end of the survey, participants were prompted with the opportunity to complete an additional 15 minute interview if they have experienced sexual pain. The purpose of the interviews was to allow participants to share their opinions and experiences about pain during sex in a more in-depth format. The interviews were completed virtually on Microsoft Teams calls with cameras off for the comfort, accessibility, and convenience of the participants.

3.4. Analysis

Data was analyzed quantitatively, using Qualtrics crosstabs and visualization software, and qualitatively, using Nvivo coding software. Qualitative analysis of open-ended survey questions and interviews was chosen to best represent the lived experiences of the participants and provide a richer explanation of common experiences and beliefs. Using the software Nvivo, open-ended survey responses and interview transcripts were "coded" with common themes that were observed during the data collection process in order to sort the qualitative data into categories and to see the most prominent themes. Additional codes were added throughout the coding process as other themes emerged, specifically in reference to the research questions. Once all the data was sorted into codes, I used Nvivo to sort the codes by frequency, exposing the most common themes in the data which are reported in the results. While a large portion of the analysis is qualitative, some quantitative data was used to describe the frequency of pain during sex in different populations that were represented in the survey.

4. Results

4.1. Demographics

At the end of data collection, there were 144 participants, 6 of which completed in-depth interviews. A majority of the participants were white, cisgender, heterosexual or bisexual women between the ages of 18 and 21 who were not religious and had experienced at least one mental illness/mental condition (See Table 1). The highest reported mental illnesses/conditions were anxiety (96) and depression (77), followed by ADHD (38). A majority of the study was completed by participants who self-identified as either liberal (66) and/or Democrat (53). A majority of the participants reported only having had sex within a relationship.

Table 1.
Sociodemographic characteristics of participants

Demographic	Full Sample (n=144)	
	n	%
Gender Identity		
Cisgender Woman	107	74.31
Non-binary	21	14.58
Transgender Man	11	7.64
Other	5	3.47
Race/Ethnicity		
White	104	58.1
Hispanic/Latino	27	15.08
Asian	24	13.41
Black/African American	15	8.38
Other (including Indigenous and Middle Eastern/North African)	9	5.03

Relationship Status		
In a relationship, but not married	56	38.89
Single	52	36.11
Married/ Domestic Partnership	30	20.38
Open/ Polyamorous	5	3.47
Other	1	0.69
Present Religion		
Not religious	53	36.81
Christian	31	21.53
Agnostic	27	18.75
Atheist	13	9.03
Other	20	13.89
Past Religion		
None	76	52.78
Christian	50	34.72
Other	18	12.49

90.28% of participants had experienced pain during sex at least once in their lives. Regardless of gender identity or sexuality, participants experienced pain at similar rates, with an average of 89.7% experiencing pain during sex. 94% of participants who had previously practiced Christianity had experienced pain during sex.

The following seven themes were identified from the data: (1) situations that cause pain, (2) pain during first intercourse, (3) normalization of pain, (4) pain is not "a big deal," (5) shame, (6) pressure, and (7) expectation of pain during sex.

4.2. Situations that Cause Pain

Of the participants who experienced pain during penetrative sexual intercourse, 68.46% reported that their pain persisted in later sexual experiences, while 31.54% reported that it did not. Some reported their pain eventually fading (31.54%) while others did not (68.46%). The most frequent attributions of this pain surrounded lack of arousal or pleasure specifically in the body's responses, such as lubrication (see Figure 1). One participant referenced the experience of lacking foreplay, and therefore lacking lubrication: "I found that a big factor could be that I was never 'turned on' or experienced proper foreplay before actual penetration. Foreplay can help to increase vaginal lubrication and have found that the lack of it can cause sex to be very painful."

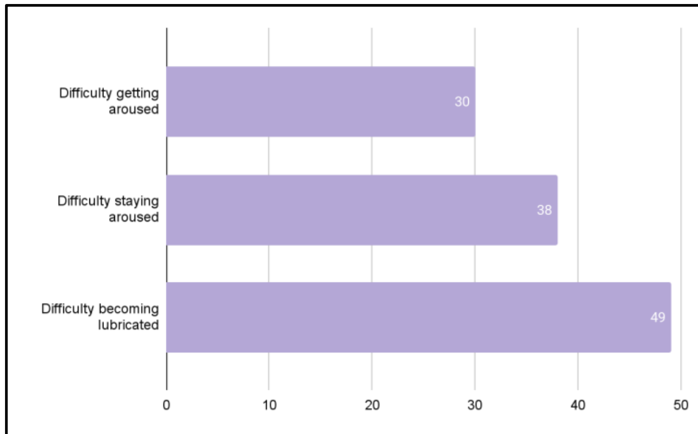

Figure 1. Do you face any of these other challenges with sexual intercourse?

There were also references to the emotional aspects of sexual preparation before penetration, such as when one participant said, "I think for the instances that that has happened, mostly just more time to get aroused, and be more intimate with my partner before getting into anything penetrative." Mental health conditions were also presented as a common attribution for painful sex. One participant, who had experienced previous sexual assault, noted that "Even though I'm in a happy and sexually active relationship, I will sometimes experience pain which is linked to my PTSD." Participants referenced that SSRI medications and testosterone also caused their sexual pain. There were also several references to menstrual related pain. A participant said, "I still have slight pain when I have sex the first couple days after my period ends," which was echoed in many other responses.

Many of the other stated sources of pain related to situational aspects of the act of sex itself. These included position ("Sometimes in different positions"), speed ("Just caused by going too fast"), size ("My pain is specific to my current partners size, not sex itself"), and roughness ("It mainly happened after rough sex").

4.3. Pain During First Intercourse

Results greatly varied for how participants rated their first penetrative sexual intercourse experience, with most reporting that it was a "somewhat positive" experience (see Figure 2). The participants who reported a positive experience often elaborated on experiencing pain at first, but it fading ("Hurt at first, and there was some bleeding, but it eventually felt better") and/or shortness of the act ("The guy I had sex with didn't last long but I still enjoyed it").

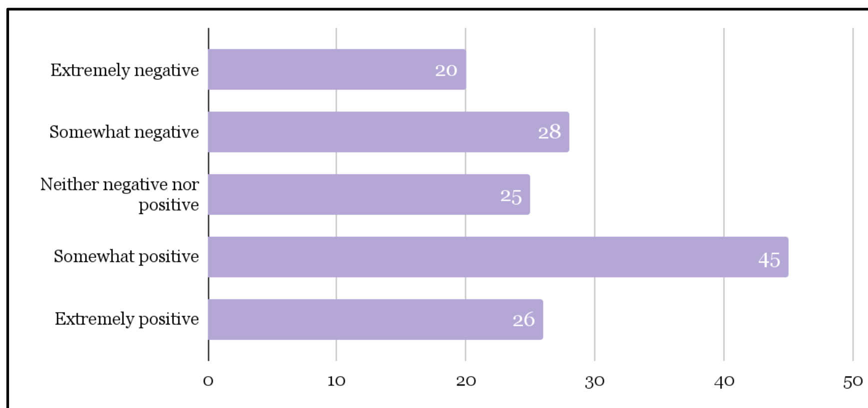

Figure 2. How would you say your first experience with penetrative sexual intercourse was?

On the other hand, many participants also elaborated on negative first experiences. 60.77% reported that they believed the first time they experienced pain was "normal." Reasons varied for why they perceived their experience to be negative, including pain, coercion, and pressure to act a certain way. One stated, "I remember that it was painful and impossible for us the first time we tried. I was terrified and mortified." Another echoed a common experience of giving in to advances from partners to have sex for the first time: "He asked and asked and asked and then I said yes." Lastly, those who reported an extremely positive experience noted safety/comfort ("We both did it safely and carefully. I felt very comfortable") and communicating with their partner(s) ("It was after almost a year of dating the person and they listened to me and were helpful in making me feel safe").

Most participants felt nervous for their first penetrative sexual intercourse (30.56%), followed by feeling somewhat nervous (29.86%) or extremely nervous (27.08%). Extremely nervous or nervous participants stated expectation of pain ("I was always told it was going to hurt"), pressure from partners ("I think I was quite terrified to be honest, but it felt like the thing I should do to keep my boyfriend happy at the time"), past pain ("I had tried penetration in the past but it hurt…"), lack of experience ("I didn't have prior experience so I didn't know what to expect"), and length of dating ("I was nervous because we had only been dating for a month"). For somewhat nervous participants, they reported, "Thought it might hurt a bit, but wasn't really too scared" and "more so nervous because it felt like a very grown up thing to go, but I wasn't really nervous during."

Participants first learned about sex through many different avenues including their parents, friends, school, traditional media, and the Internet. Those who had learned about sex for the first time from traditional media such as movies and TV had the highest rates of pain during sex (93%) compared to other sources of information.

Participants were also asked to reflect on how virginity loss is portrayed in media, porn, and other people's stories (see Figure 3). 32% said virginity loss in TV/movies was somewhat negatively portrayed, 24.80% said virginity loss was portrayed extremely positively in porn, and 33.60% of participants said that virginity loss was portrayed neither negative nor positive in other people's stories. Several discussed how media over exaggerated the gravity and magic of losing your virginity, such as one participant who said, "media portrays the loss of virginity as something monumental and life-changing" and another who said, media "always made me think the loss of virginity would be magical - it's really not, for a lot of people, including me." On the other hand, participants stated that "Porn is extremely positive for the wrong reasons," including the fetishization of the loss of virginity.

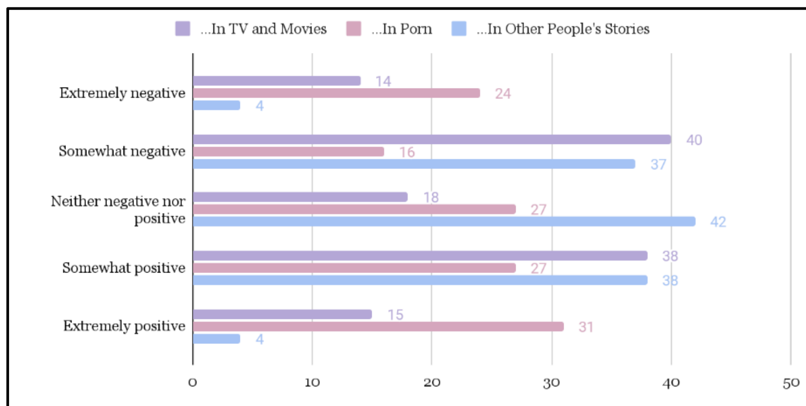

Figure 3. How do you feel that the loss of virginity is portrayed?

Lastly, participants were asked how they would describe their feelings towards the idea of "loss of virginity" when they were growing up versus in their current community/culture (see Figure 4). Many discussed how it instilled fear in them and how virginity was meant "to inspire fear in young girls who are afraid of losing their purity." Others discussed how it was portrayed negatively due to it being a "loss," such as "we are 'losing' something or that it's a central part of your identity."

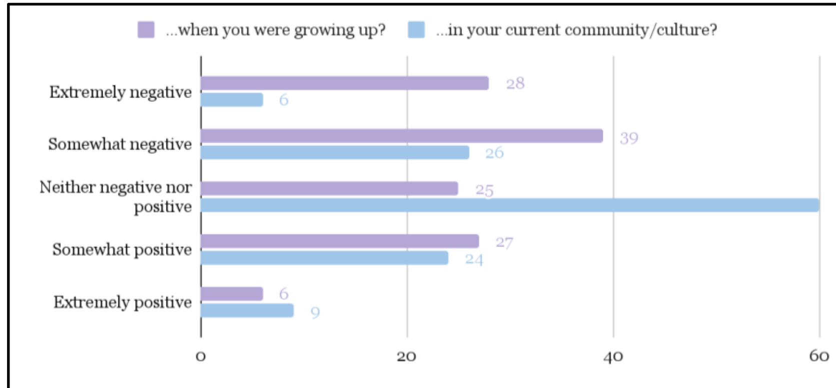

Figure 4. How would you describe your feelings towards the idea of "loss of virginity"?

Some elaborated on growing up in a religious community and how their views on virginity were imparted upon them by their religious community. They discussed the need to preserve virginity until marriage: "I feel like I thought having sex outside of marriage was a sin or meant you didn't respect yourself" and the lasting guilt that followed as a result of those views: "I was raised to believe you shouldn't have sex till marriage so I feel guilty when I do anything surrounding sexual pleasure."

4.4. Normalization

The most prominent theme that emerged was participants describing that the pain they were experiencing was normal (65.17%). They reported reasons for thinking the pain was normal such as normalization of pain during the first sexual experience ("I'd heard people say it hurt so I was sort of expecting it to the first time"), lack of knowledge ("Prior to this experience, I went to a private Catholic high school. I had no one to talk to about sex at the time"), being unsure of what level of pain is normal ("I have never felt pain that has felt unusual, but I never knew what usual pain was supposed to be during sex"), breaking of the hymen ("My hymen was unbroken and I had a small vaginal entrance; I was told by GP and [gynecologist] that first time would be painful"), bleeding (I bled afterward ('popped cherry')"), or lack of arousal ("I think I was clueless about sex and didn't realize that sex wasn't supposed to be painful. I don't think I was aroused during sex for the majority of my first year having it.").

Several participants also referenced irregularity as a reason why they believed their pain to be normal ("Sometimes sex is uncomfortable and I think that's normal"). Many other participants also referenced believing their pain was normal because they had heard of it happening to others. One participant said, "I assumed that everyone felt this way or that there was something wrong with me in particular," and in the same vein another participant said, "My friend told me she didn't enjoy her first couple times having PIV because it was painful."

Even more directly, 53.23% of participants were told that the pain they were experiencing was normal. These messages came from (see Figure 5) partners ("My ex partner said that pain to a woman during sex is normal always and I should learn to enjoy it"), friends ("...my friends told me they had similar experiences when they first started having sex so I assumed it was normal and okay"), medical practitioners ("Before I was diagnosed with PTSD I was told several times

that it was normal"), parents/guardians ("My mom always talked about it as something that had to be endured, not enjoyed"), and other sources, such as the internet.

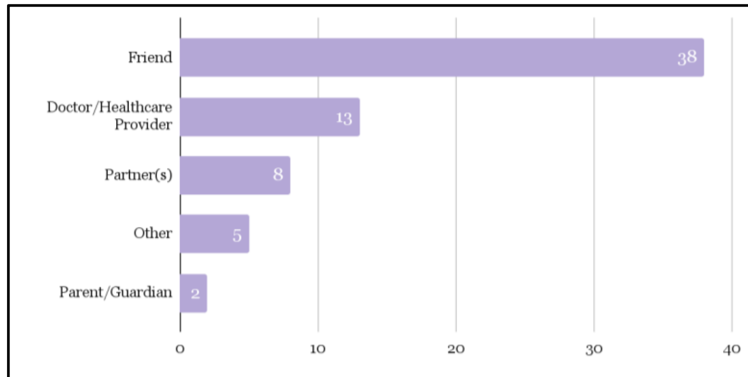

Figure 5. Who told you that the pain you experienced was "normal"?

Many participants who had not been told by others that their pain was normal had chosen to not tell anyone what they were experiencing ("I haven't really discussed with anyone"), but some were met with positive responses from partners ("Only spoke about it with my partner, who was supportive of taking time and working through it"). Participants were also asked if they agreed with the statement "The first time people with vaginas have sex is typically painful." 44.7% of participants said that they somewhat agreed with the statement. Participants who agreed with the statement were more likely to have experienced pain during sex (See Table 2).

Table 2.
Associations between normalized pain during sex and experiencing pain during sex

	Have you experienced pain during penetrative sexual intercourse?	
Do you agree with the following statement? *The first time people with vaginas have sex is typically painful.*	Yes	No
Strongly Disagree	83.3%	16.7%
Somewhat Disagree	73.7%	26.3%
Neither Agree nor Disagree	91.3%	8.7%
Somewhat Agree	93.2%	6.8%
Strongly Agree	100%	0%

For participants who did not accept their pain as normal, there were many different reactions, including communicating with partner(s) ("i asked to switch positions or take more time to prepare"), seeking medical attention ("I asked for help from the doctor"), hoping that the pain would stop on its own ("I knew it wasn't normal but was hoping it would resolve itself"), and late realizations ("After a while I realized it wasn't normal").

4.5. Pain is "Not A Big Deal"

Only a fraction of the participants who had experienced pain sought out medical attention (see Figure 6). Some saw gynecologists and some were dismissed ("...the dr was dismissive. She gave the impression that she didn't think I was engaging in sex if the insertion of the device for a physical exam bothered me") or invalidated ("I did, but I was dismissed as

'inexperienced'") by their practitioner. Of those who did seek out medical attention, some found a solution ("polyp discovered"), while others did not ("Might have vaginismus? Or endometriosis? They said testing for endo wasn't necessary but I probably have some, and seeing a pelvic floor therapist hasn't been an option right now").

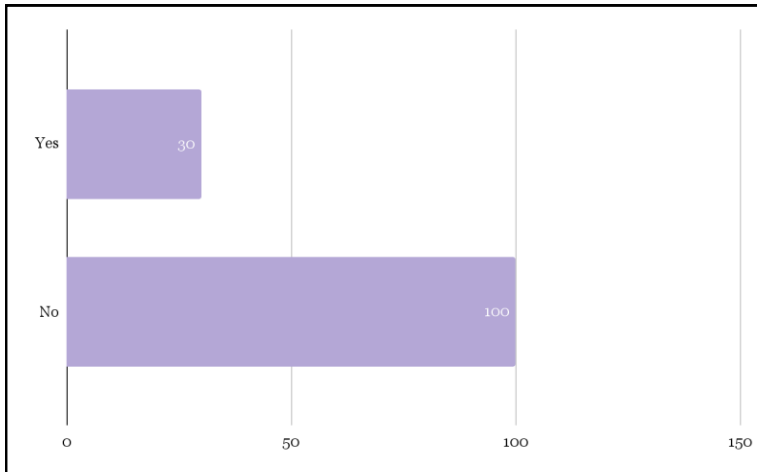

Figure 6. Did you seek medical attention for this pain?

Many participants reported trying to wait out their pain to see if it would subside on its own, often due to thinking the pain was normal, such as, "For the longest time I thought it was normal and I just had to 'push through the pain.'" This led to many saying that their pain was not bad enough to feel like they had to do something about it because it was normal to experience some pain and push through it. This was exemplified through a participant who said, "I mean, when I experienced pain, it wasn't anything super horrible that I had to stop. I just thought it was like I just had to keep going, and I thought it was the normal thing."

A few participants were formally diagnosed with sexual pain disorders (see Figure 7). Only 4 participants participated in pelvic floor physical therapy to treat a sexual dysfunction or pain during intercourse. 12 had never heard of pelvic floor physical therapy, but requested more information. For all participants who participated in pelvic floor physical therapy, it took at least 6 months from the first painful experience to the start of physical therapy, with the longest amount of time lapsed being over 5 years. Several of those who sought out physical therapy noted that "it was extremely hard to get a timely appointment with pelvic floor physical therapy" and often turned to vaginal dilators to help themselves while they waited.

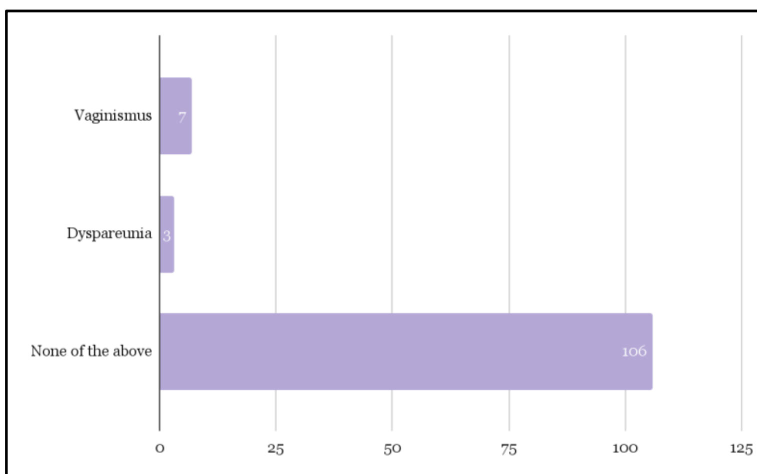

Figure 7. Do you have any of the following sexual dysfunctions/disorders diagnosed by a healthcare professional?

Those who chose not to seek out medical attention stated many reasons for not, including cultural reasons, medical reasons, and barriers to care. Cultural reasons for not seeking medical attention included shame and fear of their disorder or doctors ("...I did not physically see a doctor due to fear and feelings of shame"), fear of others finding out ("I don't want my parents to find out and it doesn't seem like its THAT big of a deal"), and embarrassment ("I was embarrassed to bring it up with my doctor"). Participants were largely comfortable discussing sex with partners and peers, which differed from their responses when it came to discussing experiencing pain during sex.

Medical reasons included pre-existing conditions ("Endometriosis runs in my family. I have a lot of symptoms that align, pain during sex is common") and symptoms of medication ("I'm on SSRI medication so I know my body has issues with sexual preparation"). In terms of barriers to care, wait time ("...have tried to make a gyno but the [wait] time is over 6 months"), bad experiences with doctors ("I rarely hear a good story about a gynecologist. Nervous they will be careless or lack empathy"), fear of additional pain ("When I've gone to the gynecologist before it's been incredibly painful"), and financial ability ("I see several doctors and adding one more to that list is too much for me financially…") all played significant roles in participants' decisions to not seek out medical care.

As opposed to seeking medical care, a larger percentage of participants sought out advice online (see Figure 8). These online searches included websites and apps such as Reddit, The FOLX Community Platform, Google, Instagram, TikTok, women's health websites, online forums, Planned Parenthood, Twitter, Quora, Healthline, WebMD, Scarleteen, podcasts, Flo, Aavia, and other online articles. However, it is important to note that many of the participants who had first learned about sex through the Internet/social media had experienced pain during sex (90.4%).

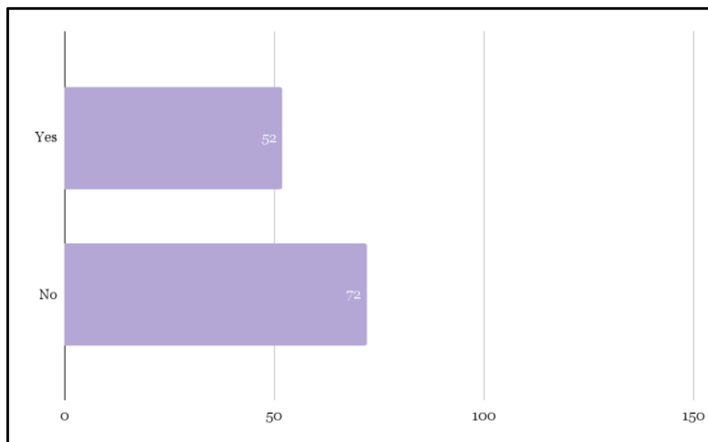

Figure 8. Did you seek out online communities or answers to your questions online when you started experiencing pain during sexual intercourse?

4.6. Shame

Another common theme experienced by participants was shame (see Figure 9). Those participants who said that they currently feel shame/guilt surrounding sex had a much higher rate of pain during sex (97.1%) than those who did not feel shame/guilt (87.4%).

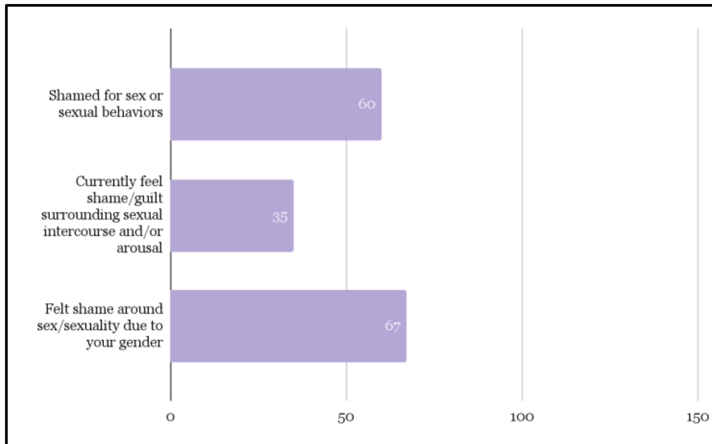

Figure 9. Shame experienced by participants in relation to sex and sexual behaviors

One common source of shame was the family and/or the home. Although 62.40% of participants said that sex was discussed neither negatively nor positively in their home growing up, larger percentages of participants reported it being discussed negatively over positively. Multiple people said they were shamed by their mothers, such as, "My mom called me a slut and was mad at me when she found out I gave a guy head." Some stated that they were generally shamed by their parents or family ("My parents were never open about sex") or were accused of sexual activity ("Shamed for anything related to wanting a partner or to be sexually active, and frequently accused of such activity and then yelled at"). Participants referred to their parents' views on sex as "traditional" (17.62%), open minded (13.41%), conservative (13.03%), and "old-fashioned" (12.64%). Others reported being shamed by another aspect of their community such as school ("called a [slut], hoar, etc when word got out for my first time") or church ("Mildly in a church as a collective").

Another common theme related to shame that was discussed was the expectation or pressure of waiting until marriage to have sex. 17.69% of the participants said that they currently or at one point during their lives identified as abstinent, which for the purposes of the study is defined as waiting until marriage to have sex. This also tied in to some participants' experiences of pain such as one who said that she was "just feeling these like, conflicting emotions of like, oh, you're not supposed to have sex, but because you can't have sex without pain, there's something wrong with you." Also, those who received abstinence-only sex education in school or at home had higher rates of pain during sexual intercourse (See Table 3).

Table 3.
Rates of painful sexual intercourse by level of sex education received

	Have you experienced pain during penetrative sexual intercourse?	
	Yes	No
Sex Education		
No sex ed	100%	0%
Comprehensive sex ed in school	88%	12%
Comprehensive sex ed at home	80%	20%
Abstinence only sex ed in school	91.4%	8.6%
Abstinence only sex ed at home	93.8%	6.3%
Sex ed in biology/health class	91.5%	8.5%
First sex ed in college	100%	0%

Lastly, 51.54% of participants reported feeling shame around sex/sexuality due to their gender. Several discussed the converse expectations about virginity for women such as "If you [lose] it too late [you're] a prude if you [lose] it to [early] [you're] a whore." This also led to fear and avoidance of sex: "I used to worry that if I expressed desire to do things like that, even to a partner, I would be see as promiscuous and dirty because women weren't supposed to want that."

4.7. Pressure

Although many participants said that what made them decide to have sex for the first time was that they were ready, many also highlighted experiences of pressure, either societal or interpersonal. Several referenced a societal idea that sex was a part of love, and therefore, they felt they needed to participate in it. One participant said, "I think love may have contributed in a small way. I was really too young to understand love and to separate a loving relationship from rather unhealthy relationship dynamics."

Many participants also reported pressure of some kind from friends ("My partner was 2 years older than me and was about to turn 18. He and our friends joked about how we needed to hurry to have sex before it became illegal due to the age difference.") or partners ("We were both flustered teens but I felt like he was the one that pushed it on me"). Also, participants who reported that they decided to have sex for the first time because their partner wanted to had the highest rates of pain during sex (91.8%) out of all the participants who answered the question about their decision to have sex. Lastly, some noted feeling pressure related to ideas of virginity. These responses included "My friends had made a huge deal of losing their virginity - I think I felt a bit pressured by this," "I didn't want to be a virgin anymore," and "Teased for being a 'virgin'."

Another participant said that she "... felt like the need to keep [her] boyfriend interested in [her] outweighed pain." This was a common theme displayed by participants (see Figure 10). This often manifested in pushing through pain in order to make sure their partner was pleased, such as one instance in which a participant said she would "...just deal with it for the thirty seconds or so that it sucks." In terms of pressure to perform, it was frequently related to their partner's

pleasure, such as one participant who said "thought i had to perform well for my partner to please my partner." Additionally, 60% of participants reported that they feel pressure to say "yes" to sex or feel negative feelings about saying "no" to sex, such as "I often apologize and feel guilt for pushing off sex" and "I feel bad for saying no, but I'm not pressured into it."

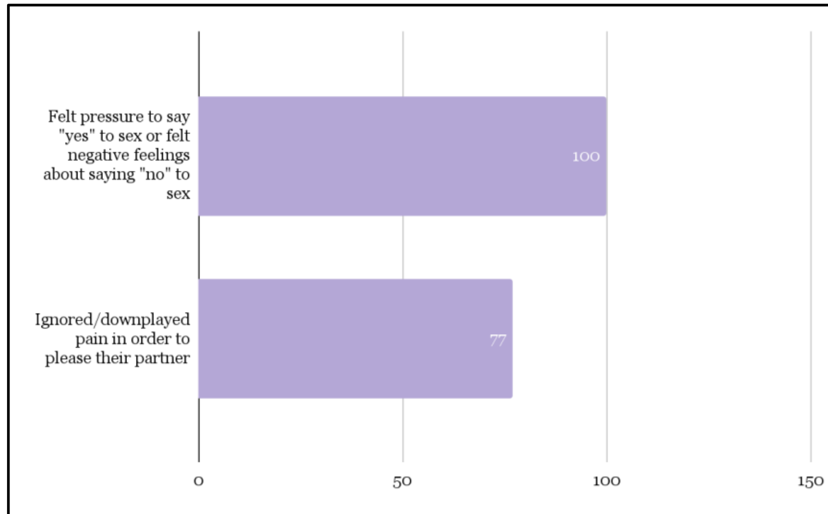

Figure 10. Shame experienced by participants in relation to sex and sexual behaviors

4.8. Expectation of Pain During Sex

Participants greatly differed on how they felt about sex growing up. However, those who had a negative perception of sex during childhood had higher rates of pain during sex than those who had a more positive perception. Many attributed this to the expectation that sex would be painful, at least for the first time. A lot of these ideas came from friends and culture, such as "I knew it wasn't going to feel the best, so my friends kind of told me that it might hurt a little, that I might bleed, and I did," and were reinforced by personal experiences in which the expectation of pain was proved to be correct.

Many also discussed pain due to bleeding or the breaking of their hymen. Over half (59.20%) of participants said that they expected to bleed during their first time having penetrative sex. This was perceived as normal by several participants, including one who said, "Obviously, bleeding typically results from pain so it was expected." Of those who said they expected to bleed during their first penetrative sexual intercourse, 91.9% had experienced pain during sex as opposed to 86.3% who did not expect to bleed.

5. Discussion

This study has several potential limitations. The sample size of the study could have been larger which would have aided in the ability to draw statistical conclusions based on the data. The sample was also not as diverse as desired in categories such as race/ethnicity and political affiliation, leading to lack of analysis of demographic qualities as they relate to pain during sex. Secondly, the number of interviews completed was low and the study would have been better supported with more in-depth interview data. The study is also inherently affected by my bias as a person who has the experience of pain during sex and has preconceived notions about what factors had a strong effect on my experience. Lastly, survey and interview question phrasing often asked yes or no questions, which limited the ability to complete more in-depth statistical tests.

Although there is research about sexual pain, less research exists about the lived experiences of people who experience sexual pain and their beliefs surrounding it. In the current study, I found that participants attributed many different sociocultural factors to influence their experiences of sexual pain. All of the participants in the study lived complex, intersectional lives that affected their sexual experiences, as mentioned in the theoretical frameworks of the study methods (Crenshaw, 1989). I also found that many of the participants believed their sexual pain to be normal or that this pain was normalized in society. The U.S. 's culture surrounding virginity, AFAB people's sexualities, and the minimizing of women's pain negatively affect AFAB people's experiences of painful penetrative sexual intercourse. Furthermore, the pain AFAB people experience during penetrative sexual intercourse is normalized through harmful ideas of virginity loss, shame surrounding sexuality, lack of sex ed, and lack of supportive resources.

My study found similar results on situations that cause pain for AFAB people as found by Mitchell et al., Prause et al., and Sörensdotter from the literature review (2017; 2015; 2017). Many participants had specific reasons for their pain, such as position, partner's penis size, lack of lubrication, or proximity to menstruation, rather than an overarching experience of sexual pain. It is important to note that these specific attributions were rarely unique to just one participant and often revealed a pattern of normalized painful sexual intercourse from interpersonal discussions surrounding these experiences. Medical conditions that caused pain during sex (such as vaginismus) were mentioned considerably less by the participants in this study than in existing literature on painful sex, such as Campbell's Contemporary Sex Therapy (2020, p. 18). Lastly, sexual assault as a cause of painful sex was less common than what was found by Davidson (Davidson, 2023, p. 11).

There were also many similarities between pain during first intercourse in my study and discussions of virginity in the literature. Participants discussed their expectation of pain during sex, with several attributing it to the hymen, such as in Abboud et al.'s study about Muslim women's perceptions of virginity (2015). Many also discussed the pressure of purity culture and avoiding premarital sex due to religion, consistent with Azim's idea of religion causing sex guilt (Azim et al., 2021). Lastly, my participants were consistent with Abboud et al.,'s argument that their participants' virginities were objectified "for the world to evaluate" (2015).

Our theme of normalization was consistent with how Azim and colleagues described the normalization of sexual pain in Western culture leading to the underreporting of it (Azim et al., 2021). Much of this normalization corresponded with lack of knowledge surrounding sexual pain conditions, similar to Campbell's research, as many of the participants did not seek medical help, did not know pain was not normal, and did not have any knowledge of about pelvic floor physical therapy (2020).

Many also discussed how their pain was "not a big deal" for several reasons, notably like the sex guilt and partners' pleasure discussed in the literature review. Although the word guilt was only mentioned a few times by participants, many discussed their feelings and experiences, like Divasto's definition of sex guilt and how it prevented them from communicating about their pain and seeking care for it (Azim et al., 2021; Divasto, 1981, p. 119). When partners were discussed in the study, it was often in relation to the pain, sexual pressure, and prioritizing the partner's pleasure, all common themes identified in the existing literature (Carter, 2019).

In terms of shame, participants echoed similar experiences of religious shame to those noted by previous researchers. They spoke of "negative talk about the loss of virginity and expressions of female sexuality" and sex guilt preventing them from seeking social or medical support (Ait Souabni et al., 2023). They also echoed Campbell's idea that doctors often give no solution or deny patients' experiences of pain, which can lead to shame and fear of doctors

(2020, p. 11). My results partially aligned with the expectation of pain during sex included in the existing literature. Several participants referenced the anxiety, avoidance, and hyper-vigilance as mentioned by Campbell in conjunction with their expectation of pain (Campbell, 2020, p. 107).

6. Conclusion

This study has several important implications. First, sexual pain is a complex sociocultural issue that has been deeply normalized in U.S. culture, allowing for many people's experiences to slip through the cracks of medical and social supports. There must be better ways of "addressing…sexual pain as a lived, embodied, biological, and physiological experience that is simultaneously shaped by social norms" (Farrell & Cacchioni, 2012). Sexual pain is not entirely biological and does not exist outside the complexities of social norms, gendered expectations, and more sociocultural factors.

The study results have implications for the ways in which society understands sexual pain. Participants heavily elaborated on how their friends, families, doctors, media, and more all discussed sexual pain as something to expect, something normal, and something to be endured. This study illuminates the harmfulness of this rhetoric and highlights the need for increased education on painful sexual experiences through comprehensive sex education, education of medical practitioners, and media literacy education.

Based on the findings of this study, I recommend that medical practitioners are trained on sexual pain, as this was one of the most common ways that participants' pain was normalized besides from friends, which is more difficult to improve from an education standpoint. Medical practitioners should have developed methods of screening patients for pain during sex and should be equipped to discuss options available to the patient experiencing pain.

More research is also needed on sexual pain amongst people assigned female at birth. The research design of this study focused on first-hand testimony and the lived experiences of the participants, which should be modeled in future research on this topic to allow for the varying experiences of AFAB people to be analyzed for all of their intersections.

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